Communication failure

Why communication fails in the operating room

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The reasons behind miscommunication need understanding in order to find the right solutions

There is evidence from a variety of sources that communications between members of healthcare teams emerge as a key factor in poor care and are especially apparent where medical errors occur. Lingard *et al*[1] take this as their starting point for an observational study of communication failures in operating theatres published in this issue of *QSHC*. They found that 31% of all communications could be categorised as a failure in some way—whether the information was missing or the timing was poor, or where issues were not resolved or key people absent. Moreover, more than a third of these failures had negative effects on what was happening. If we multiply all that by the million patients treated daily in the UK alone, we are into an overwhelming amount of miscommunication. Lingard *et al*[1] suggest training interventions to remedy this but, to make such training appropriate, the causes of poor communication need to be considered.

Some of these causes will be systemic. Team instability—for example, different scrub nurses—can help to produce inferior outcomes in terms of care.[2] This shows the importance of human resource management in ensuring good teamwork where members can know and understand each other well. Research in other fields has shown that the longer a team is together, the better its results,[3] and at least part of this is likely to reflect improvements in communication. Organisational and team policies about communication are also important;[2] a policy which disallows distraction in the operating room appears beneficial, probably because of the inevitable effects of distraction on communication.

Another systemic cause which is often ignored by research concerns resources. Having more than minimal staffing—known in high reliability organisations as ''redundancy''[4]—allows people the time to communicate properly,[5] whether by ensuring that the timing is appropriate or that the person speaking can check that the receiver has understood what was said. Communication is not simply about transmitting but also receiving, including the knowledge that the transmission was understood in the way intended. Redundancy of communication may also be a concept to consider—team meetings outside the immediate task may seem like luxury in today's health services but it is from these ''ordinary'' interactions that rapport can be developed and communication improved.

Having sufficient resources in terms of staff and equipment will also have an indirect effect on communication by its effect on the stress levels of team members. No one communicates well when they are very stressed, and surveys consistently show that about 28% of clinical staff have stress symptoms above threshold levels.[6] This human resource management issue demands both systems interventions in terms of staffing and support and interventions to increase individual resilience.

Other individual causes of poor communication centre round personality. For example, introverts (and there are many of them in hospital medicine[7]) may need training in making all the communications necessary and making them clearly. Extroverts, on the other hand, may need help in reducing their communications to those that are essential to the purpose. Personality may also be a factor in the extent to which leaders have the ability to encourage participative communication from team members, even when it may be to say that the leader has done something wrong.[8] This ability to hear and even welcome negative messages is important in aviation safety and can be taught.[9]

One of the key reasons for miscommunication mentioned by Lingard *et al*[1] arises from the power relationships that exist in health care as a result of different professional groups with traditionally different status, and of a culture where hierarchy still resembles the military model. Tannen[10] has described how misunderstandings arise during conversations between people of different status and sex because of their very different ways of communicating—for example, to demonstrate their status on the one hand, or to show their solidarity with colleagues on the other. There is a human benefit to this solidarity, but a similar benefit to retaining individual power. Professional language—sometimes difficult to understand by others—might be seen as a way of maintaining this power. The recognition of these differences is an important step towards changing them, but a difficult one since the conflicting human needs of involvement and independence may underlie them. The thinning of professional boundaries through shared training and other experiences should be a useful step towards improving communication.

The reasons behind miscommunication are therefore deeply complex. Changing it will require interventions at both the systems level and the individual level. However, any change is never likely to be permanent, so the checklist proposed by Lingard *et al*[1] may well be an essential safety net for occasions when other more human interactions occur and communication fails.

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REFERENCES

1 **Lingard L**, Espin S, Whyte S, *et al*. Communication failures in the operating room: an observational classification of recurrent types and effects. *Qual Saf Health Care* 2004;**13**:330–4.
2 **Carthey J**, de Laval MR, Wright DJ, *et al*. Behavioural markers of surgical excellence. *Saf Sci* 2003;**41**:409–25.
3 **Fouchee HC**, Helmreich RL. Group interaction and flight crew performance. In: Weiner EL, Hagel DC, eds. *Human factors in aviation*. San Diego, CA: Academic Press, 1988:189–227.
4 **Roberts K**. Managing high reliability organizations. *Calif Manage Rev* 1990;**32**:101–13.
5 **Firth-Cozens J**. Teams, culture and managing risk. In: Vincent C, eds. *Clinical risk management*.2nd ed. London: BMJ Books, 2001.
6 **Firth-Cozens J**. Interventions to improve physicians' well-being and patient care. *Soc Sci Med* 2001;**52**:215–22.
7 **Clack GB**, Allen J, Cooper D, *et al*. Personality differences between doctors and their patients: implications for the teaching of communications skills. *Med Educ* 2004;**38**:177–86.
8 **Firth-Cozens J**. Organisational trust: the keystone to patient safety. *Qual Saf Health Care* 2004;**13**:56–61.
9 **Helmreich RL**, Willhelm JA. Outcomes of crew resource management training. *Int J Aviat Psychol* 1991;**1**:287–300.
10 **Tannen D**. *That's not what I meant!*. London: Virago, 1992.